

9580

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09584

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Calvert	MARYLAND	STATE Maryland	COUNTY Calvert
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Chesapeake Beach, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert County Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)		
Baby Boy Chase	October 16 19 55		
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 10-5-55
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: (If under 1 year) (If under 24 hrs.)
			yrs. Months Days Hours Min.
13. FATHER'S NAME: Carol Holland		14. MOTHER'S MAIDEN NAME: Bliss Chase	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: Bliss Chase, Chesapeake Beach, Md	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
764.0 Immediate cause (a) Dehydration and Malnutrition secondary to Diarrhea. Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE Paul F. Men	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/17/55	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 10/17/55
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF 10-18-55	NAME OF CEMETERY OR CREMATORY St. Edmunds
DATE REC'D BY LOCAL REG. 10-18-55	REGISTRAR'S SIGNATURE N.W. Ward	24. FUNERAL DIRECTOR P.E. Sewell, Prince Frederick, Md

2005234345

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 20 1955

RECEIVED

9581

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

COUNTY Calvert

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Prince Frederick

LENGTH OF STAY (In this place)

18 1/2 hrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

644 Calvert County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY CalvertCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dwings X

STREET ADDRESS (If rural give location)

1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

SwordolphCook

4. DATE (Month)

(Day)

(Year)

OF

DEATH: October 91955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FemaleWhiteSingleFebruary 10 19532 yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

MarylandU.S.A.

13. FATHER'S NAME:

Alvin Gray

14. MOTHER'S MAIDEN NAME:

Hilda Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Hilda Cook Dwings 25

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

057.0

IMMEDIATE CAUSE

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Convulsions24 hrs

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☒ at work ☐ at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased

alive on _____, 19____, and that death occurred at 5:45 A.M. from the causes and on the date stated above.

SIGNATURE

H. W. Ward M.D.

ADDRESS

DATE SIGNED

10/9/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10.10.55H. W. WardLeroy Berry Huntingtown, Md.

MARGIN RESERVED FOR BINDING

U. S. BUREAU

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09586

9582

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cabaret</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Cabaret</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Prince Frederick</u>		4 mo.		TOWN <u>Mutual</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cabaret County, Ind</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Elizabeth S. Harkness</u>				(Month) (Day) (Year) <u>Oct. 23, 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 2, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cabaret County, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Parran</u>				14. MOTHER'S MAIDEN NAME <u>Mary Evelyn Solters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Robert A. Harkness, Mutual, Ind.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> 19 <u>55</u> , to <u>Oct 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>55</u> , and that death occurred at <u>3:15</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Harkness</u> M.D.				ADDRESS (Street, city, town, state) <u>St Leonards Ave</u>		DATE SIGNED <u>10/24</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 2-5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem. Port Republic, Ind.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Ind.</u>		ADDRESS	
DATE <u>10-24-55</u>							

CERTIFICATE OF DEATH

0-225

Form 10-1-1

USE FOR MEMBERS WHOSE DEATHS ARE REPORTED

STATE OF MARYLAND

NAME OF DECEASED: JOHN J. SMITH
 SEX: MALE AGE: 45
 DATE OF BIRTH: 1910
 PLACE OF BIRTH: NEW YORK
 OCCUPATION: CLERK
 MARITAL STATUS: MARRIED
 DECEASED AT: HOME
 CAUSE OF DEATH: HEART DISEASE
 PLACE OF DEATH: 1234 MAIN ST, BALTIMORE, MD
 DATE OF DEATH: 1955
 TIME OF DEATH: 10:00 AM
 SIGNATURE OF DECEASED: _____
 SIGNATURE OF WITNESS: _____
 SIGNATURE OF PHYSICIAN: _____
 SIGNATURE OF CORONER: _____
 SIGNATURE OF MINISTER: _____
 SIGNATURE OF CHURCH: _____
 SIGNATURE OF BURIAL: _____
 SIGNATURE OF CREMATION: _____
 SIGNATURE OF OTHER: _____

IN MEDICAL CERTIFICATION

BUREAU V. S.

DEC 4 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9583

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09587
Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Mtgomery</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cambridge Island</u>				TOWN <u>Kensington</u>		15x2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>10608 Concord St</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Marie</u>		(Middle) <u>Jacqueline</u>		(Last) <u>Loehler</u>		(Month) (Day) (Year) <u>10 23 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>8/12/74</u>	
						9. AGE last birthday: <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
				<u>Germany</u>		<u>USA</u>	
13. FATHER'S NAME: <u>Saytter</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT'S ADDRESS:	
						<u>John J. Loehler</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
900.0 Immediate cause (a) <u>Cerebral Vascular Accident</u>						<u>3 days</u>	
DUE TO Antecedent cause(s) (b) <u>Fell down steps</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Hypertension & Uremia</u>							
DUE TO <u>Fell down stairs</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>		21c. (City or town) (County) (State) <u>Port Republic Calvert MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>10/23/55 38 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down stairs</u>		09	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>H. Ward</u>				CHIEF MEDICAL EXAMINER DATE SIGNED <u>10/23/55</u>			
				DEPUTY MEDICAL EXAMINER			
				M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF: <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill</u>		LOCATION (City, town, or county) (State): <u>Calvert MD</u>	
DATE REC'D BY LOCAL REG: <u>10-23-55</u>		REGISTRAR'S SIGNATURE: <u>N W Ward</u>		24. FUNERAL DIRECTOR: <u>Wesley Hines & Co</u>		ADDRESS: <u>2801-14th St NW Wash. DC</u>	

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL BUREAU OF INVESTIGATION
FEDERAL BUREAU OF INVESTIGATION

BUREAU V. 3

OCT 27 1955

RECEIVED

9584

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Calvert</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Calvert</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Prince Frederick</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mutual</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>			STREET ADDRESS (If rural give location) <u>/</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James</u> <u>MacKail</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>10 - 15</u> <u>1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>School</u>	8. DATE OF BIRTH: <u>May 20, 1940</u>	9. AGE last birthday <u>15</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>School</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME: <u>Joseph MacKail</u>			14. MOTHER'S MAIDEN NAME: <u>Elsie Parker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS: <u>Mrs. Elsie Parker - Mutual, Md.</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
204.0 IMMEDIATE CAUSE (A) <u>Acute anemia - Emission</u>					
ANTECEDENT CAUSE (B) <u>Acute lymphatic leukemia</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-11</u> , 19 <u>55</u> , to <u>10-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-13</u> , 19 <u>55</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.					
SIGNATURE <u>Dr. Williams</u>		M. D. <u>Dr. Leonard</u>		DATE SIGNED <u>10-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Little Rehoboth Church</u>	
LOCATION (City, town, or county) (State) <u>Cal. Co. Md.</u>		24. FUNERAL DIRECTOR <u>LeRoy Berry</u>		ADDRESS <u>Huntingtown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-14-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE

TO DIRECTOR, FBI

FROM SAC, [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

BUREAU V. E.

RECEIVED OCT 17 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9585

09589
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Monteval</u>				TOWN <u>Monteval</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>Baby girl</u> (First) <u>Marshall</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX: <u>7</u>		6. COLOR OF RACE: <u></u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>5</u>		8. DATE OF BIRTH: <u>9/26/55</u>	
9. AGE last birthday: <u>7</u> yrs.		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u></u>				10b. KIND OF BUSINESS OR INDUSTRY: <u></u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
13. FATHER'S NAME: <u>George Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Elaine Mary Marshall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u></u>				16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Elaine Mary Marshall</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
772.0 Immediate cause (a) <u>Malnutrition</u> DUE TO						5 days	
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Died intestate</u>							
19a. DATE OF OPERATION: <u></u>				19b. MAJOR FINDING OF OPERATION: <u></u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				(State) <u></u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <u></u>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u></u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u></u>		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. H. Ward</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/10/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>J. H. Marshall - Monteval, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10-6-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Mt. Harmony</u>		LOCATION (City, town, & county) (State): <u>Owings, Calvert, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10-6-55</u>		REGISTRAR'S SIGNATURE: <u>J. H. Ward</u>		24. FUNERAL DIRECTOR: <u>J. H. Marshall - Monteval, Md.</u>		ADDRESS: <u></u>	

2095161394

RECEIVED

OCT 10 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9586

CERTIFICATE OF DEATH

Reg. Dist. No.

09530

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Republic</u>			
X TOWN <u>Chesapeake</u>		<u>26 hrs.</u>		STREET ADDRESS (If rural give location) <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Albert</u> <u>the Carmick</u>				<u>October 8</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 15 1890</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <u>Farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John the Carmick</u>				14. MOTHER'S MAIDEN NAME: <u>Liza Hunt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Isabelle the Carmick-Port</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE				(A) <u>Cerebro-vascular accident</u>		26 hrs.	
ANTECEDENT CAUSE (S)				(B) <u>Diabetes mellitus</u>		3 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		9:30 PM		11:30 PM			
22. I hereby certify that I attended the deceased from <u>10-7</u> , 1955 to <u>10-9</u> , 1955, that I last saw the deceased alive on <u>10-9</u> , 1955, and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Merle L. Gibson Jr.</u>				ADDRESS <u>M. D. Pr. Fred.</u>		DATE SIGNED <u>10-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>10-12-55</u>		<u>Brown</u>		<u>Calvert</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-10-55</u>		<u>H. W. Ward</u>		<u>P. E. Sewell</u>		<u>Prince Frederick Md.</u>	

REAU V. S.

09592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9587

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Solomons Island</u>			
X TOWN <u>Solomons Island</u>		<u>66 yrs.</u>		STREET ADDRESS (If rural give location) <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>houise</u>		(Last) <u>Rekar (Rekar)</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>12</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>May 6 - 1889</u>		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles F. Files</u>				14. MOTHER'S MAIDEN NAME: <u>Sophie hubby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-0006</u>		17. INFORMANT & ADDRESS: <u>Mrs. Eleanor Hipple Solomons</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Coronary Artery Thrombosis</u>							
DUE TO							
(B) <u>Arteriosclerosis</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-12</u> , 19 <u>52</u> , to <u>10-12</u> , 19 <u>55</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Merle L. Gibson</u>		DATE THEREOF <u>Oct. 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist Ch. Solomons, Md</u>		LOCATION (City, town, or county) (State)	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE REC'D BY LOCAL REGISTRAR <u>10-13-55</u>		REGISTRAR'S SIGNATURE <u>H.W. Ward</u>		24. FUNERAL DIRECTOR ADDRESS <u>G.A. Harkness & Son - Mutual, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

CERTIFICATE OF VITAL STATISTICS

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of birth		6. Date of birth		7. Cause of death		8. Place of death	
9. Occupation		10. Marital status		11. Duration of illness		12. Name of physician	
13. Name of informant		14. Signature of informant		15. Signature of physician		16. Signature of registrar	
17. Date of registration		18. Name of registrar		19. Name of hospital		20. Name of city	
21. Name of county		22. Name of state		23. Name of country		24. Name of continent	
25. Name of island		26. Name of territory		27. Name of district		28. Name of parish	
29. Name of township		30. Name of village		31. Name of hamlet		32. Name of farm	
33. Name of plantation		34. Name of estate		35. Name of manor		36. Name of lordship	
37. Name of barony		38. Name of viscountcy		39. Name of earldom		40. Name of dukedom	
41. Name of principality		42. Name of kingdom		43. Name of empire		44. Name of realm	
45. Name of monarchy		46. Name of republic		47. Name of democracy		48. Name of autocracy	
49. Name of oligarchy		50. Name of aristocracy		51. Name of plutocracy		52. Name of technocracy	
53. Name of bureaucracy		54. Name of theocracy		55. Name of clerocracy		56. Name of gerontocracy	
57. Name of aristocracy		58. Name of nobility		59. Name of gentry		60. Name of peasantry	
61. Name of bourgeoisie		62. Name of proletariat		63. Name of middle class		64. Name of lower class	
65. Name of upper class		66. Name of elite		67. Name of ruling class		68. Name of dominant class	
69. Name of ruling class		70. Name of dominant class		71. Name of ruling class		72. Name of dominant class	
73. Name of ruling class		74. Name of dominant class		75. Name of ruling class		76. Name of dominant class	
77. Name of ruling class		78. Name of dominant class		79. Name of ruling class		80. Name of dominant class	
81. Name of ruling class		82. Name of dominant class		83. Name of ruling class		84. Name of dominant class	
85. Name of ruling class		86. Name of dominant class		87. Name of ruling class		88. Name of dominant class	
89. Name of ruling class		90. Name of dominant class		91. Name of ruling class		92. Name of dominant class	
93. Name of ruling class		94. Name of dominant class		95. Name of ruling class		96. Name of dominant class	
97. Name of ruling class		98. Name of dominant class		99. Name of ruling class		100. Name of dominant class	

BUREAU V. 3

1 OCT 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09593

Item 7, Film G187 10-14-55 et

9588

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> 47X-3			
X TOWN <u>Prince Frederick</u>		14 days		STREET ADDRESS (If rural give location) <u>1916-13th St. S.E.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: 10 4 1955			
<u>Ernest Franklin Shephard</u>							
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>18 85</u>	9. AGE last birthday: <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Mark Shephard</u>				14. MOTHER'S MAIDEN NAME: <u>Rosalie Fairfax</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> If Yes, give war or dates of service: <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. Helen Edith Shephard (wife) Owings Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>442X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cardio-Vascular Renal Disease</u>							4 yrs
DUE TO							
(B) <u>Hemiplegia</u>							10 wks
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/15</u> , 19 <u>55</u> , to <u>10/14</u> , 19 <u>55</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.							
alive on <u>10/14</u>		DATE SIGNED <u>Oct 10/15/55</u>					
SIGNATURE <u>H W Ward</u>		M. D. <u>Owings</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Harmony Calvert Co Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>10/16/55</u>		REGISTRAR'S SIGNATURE <u>Grace L. Nicholas</u>		24. FUNERAL DIRECTOR <u>Mr H. Hutchins</u>		ADDRESS <u>Owings Md.</u>	

RECEIVED

NOV 11 1955

RECEIVED

RECEIVED

9589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 52

1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lower Marlboro</u> TOWN <u>Lower Marlboro</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lower Marlboro</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Lower Marlboro md</u> TOWN <u>Lower Marlboro</u> STREET ADDRESS (If rural, give location) <u>Lower Marlboro</u>	
--	--	---	--

3. NAME OF DECEASED: (Type or Print) <u>Lawrence M. Kee</u> (First) <u>Wells</u> (Middle) <u>Wells</u> (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>24</u> (Year) <u>1955</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>May 18, 1886</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Owner</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>W. M. Kee</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Ellen Sunderland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Lawrence Wells, Lower Marlboro md</u>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary embolism</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____
--	--	--

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead by car</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		21. HOW DID INJURY OCCUR? <u>Was felling in car</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY) <u>Lower Marlboro Calvert</u>		21c. (City or town) (County) (State) <u>md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 24 55 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Was felling in car</u>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: [Signature] **CHIEF MEDICAL EXAMINER** ☐ **DATE SIGNED** 10/24/55
M. D. DEPUTY MEDICAL EXAMINER ☒ **ASSISTANT MEDICAL EXAM.** [Signature]

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lower Marlboro</u>		LOCATION (City, town, or county) (State) <u>Lower Marlboro md</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU OF THE
MAY 1915

BUREAU V. S.

OCT 31 1915

RECEIVED